SUPPLEMENT

Royal Commission on the NHS

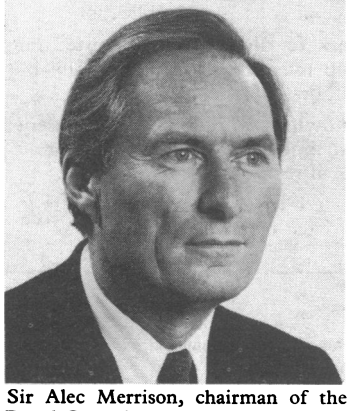
The report of the Royal Commission on the NHS was published on 18 July. We publish here the introduction to the chapter setting out the Commission's conclusions together with all the recommendations and its comments on the future. A leading article appears at p 227 and a briefing on the background to the Royal Commission at p 286.

Introduction

In this chapter we bring together our conclusions and recommendations, but we thought it would be helpful to put them in the context of a brief account of our main lines of work and thinking.

We should wish to emphasise first that we have tried always to relate our discussion, no matter what the topic, to the patient, his family, and those serving them. Will our recommendations help the patient, and help those who serve him to do so more effectively?

We have tried to take the widest possible view of the NHS and to see it whole. We have also tried to view it not in isolation but in the context of the many links it has with other services and institutions. At no time have we thought that any other approach to our task would be useful, if indeed any other were possible, but this has the disadvantage that we have dealt only cursorily, and sometimes perhaps even superficially, with important topics. Our work can therefore be regarded only as a beginning. It is not for us to say whether it is good or bad, and it must now be put to the refining fire of public discussion. But we hope that even in those areas where we have necessarily had to work sketchily those who will be discussing this report will at least have no trouble in seeing which way we are pointing.


Sir Alec Merrison, chairman of the Royal Commission.

We are all too conscious that our report will be disappointing to those who have been looking to us for some blinding revelation which would transform the NHS. Leaving to one side our own capacity for revelation of this kind, we must say as clearly as we can that the NHS is not suffering from a mortal disease susceptible only to heroic surgery. Already the NHS has achieved a great deal and embodies aspirations and ideals of great value. The advances to be made—and which undoubtedly will be made—will be brought about by constant application and vigilance.

In this connection we should like to quote the wise words of the late Sir Richard Clarke, who was Second Secretary at the Treasury when he spoke in 1964 about the management of public expenditure in the following terms:

"In the dispersed services such as education and hospitals ... units of administration are small, and their performance must be uneven. It is difficult to form a judgment about how efficient those relatively small independent units are, and how much scope there may be for saving, and by what management techniques and services this potential saving can be realised—without of course endangering the quality of local responsibility and flexibility to local circumstances which is fundamental to these services."

Sir Richard continued:

"Altogether, there is clearly no room for complacency. But it would seem difficult to argue that there is widespread inadequacy; or to point to substantial improvements which could be made readily. To improve performance is a long slogging job."

The NHS has come a long way since 1964 but if we had to sum up our general view of the present-day NHS we could think of no better words to use than those we have just quoted.

The NHS reflects the society around it—both society's aspirations towards good health and its careless attitudes towards bad health. Then again, the NHS mirrors, and always will, not only the imperfect nature of medical science but the diffuse and ill-defined understanding we have of our own health, whether good or bad. It would be comforting to think that one

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day we shall be able to mend broken minds as effectively as we can broken limbs, but we know that that must be a very distant prospect.

It follows therefore that, within its large and complex framework, the NHS must be sensitive always to the individual voice and its cry for help. It must never lapse into insularity or complacency. It should always strive for improvement and be open to new ideas and influences, rewarding initiative and leadership wherever they may be found.

Recommendations

Services to patients

(1) Proved screening programmes should be expanded.

(2) The wearing of seat belts should be made compulsory for drivers and front seat passengers in motor vehicles.

(3) Health education should be expanded, but some of the increased resources must be spent on developing more effective methods and on monitoring and validating existing and new techniques.

(4) Education authorities should examine seriously existing arrangements for health education in schools.

(5) Health education should be emphasised in the forward planning of health authorities.

(6) Funds for the Health Education Council and the corresponding bodies in Scotland should be increased to allow them to make more use of television.

(7) The health departments should make public more of the professional advice on which policies and priorities are based.

(8) All professions concerned with the care of the elderly should receive more training in understanding their needs.

(9) Further experiments in different ways of meeting the needs of elderly and other patients requiring long-term care should be undertaken urgently.

(10) The legal position regarding responsibility in the use of deputising services in Scotland should be brought into line with that elsewhere in the UK.

(11) Health authorities should keep under review the operation of the deputising services in their areas and, if they are unsatisfactory, improve or replace them.

(12) Where this does not happen already, the full costs of attendance of GPs' receptionists at training courses should be met by the family practitioner committee or health authority concerned.

(13) Before a maximum or minimum list size is adopted, considerable research on an optimum range of list sizes should be undertaken.

(14) There should be a review of the controls on the appointment of GPs exercised by the medical practices committees.

(15) The health departments should consider offering an assisted voluntary retirement scheme to GPs with small lists who have reached 65 years of age.

(16) The health departments should discuss with the medical profession the feasibility of introducing a compulsory retirement age for GPs.

(17) The health departments should continue their current plans for the expansion of community nursing.

(18) Research is required into a number of aspects of primary care.

(19) National or regional panels should be set up to provide external assessors for each new appointment of a principal in general practice.

(20) GPs should make local arrangements specifically to facilitate audit of the services they provide and the health departments should check progress with these developments.

(21) The introduction of the A4 records system in general practice should be given high priority.

(22) FPCs and health authorities should use vigorously their powers to ensure that patients are seen by their GPs in surgeries of an acceptable standard.

(23) The British National Formulary should be reissued soon in portable, loose-leaf form with separate information on drug costs, and be kept up-to-date.

(24) The health departments should introduce a limited list of drugs as soon as possible and take further steps to encou age generic prescribing.

(25) The health departments should consider whether high running costs are acting as a significant disincentive to GPs to work in health centres.

(26) The health departments should consider urgently measures to assist the development as a priority of health centres or other suitable premises to attract GPs to London and other inner city areas where sites are particularly expensive or difficult to obtain.

(27) Health authorities when establishing health centres in inner city and deprived urban areas should experiment with offering salaried appointments and reduced list sizes to attract groups of doctors to work in them.

(28) Additional financial resources should be provided to improve the quality of primary care services in declining urban areas.

(29) The establishment of pharmacies in health centres should be encouraged.

(30) Charges for NHS and non-NHS items and details of eligibility should be prominently displayed and publicised by opticians.

(31) Serious consideration should be given to widening the range of items which can be prescribed and dispensed under the general ophthalmic services.

(32) More chiropody training places should be provided and services to the elderly in the community increased.

(33) Until the implications of a shift in policy towards prevention have been identified dental student entry numbers should not be altered but flexibility in meeting demands should be achieved through the increased use of dental ancillary workers.

(34) The dental profession and Government should experiment with alternative methods of paying general dental practitioners in addition to a capitation system for children.

(35) The dental profession and Government should make rapid progress to the introduction generally of an out-of-hours treatment scheme.

(36) Dental care for long-stay hospital patients should be as readily available as it is for men and women in the community.

(37) Dental teaching hospitals should be funded directly by region or health department.

(38) The present technical college/dental hospital training schemes for dental technicians should be expanded.

(39) A standardised national basis for the collection of dental data should be introduced.

(40) Manpower in the community dental service should be increased.

(41) The Scottish system for recording all information about the dental treatment of children in the same way should be adopted in the rest of the UK.

(42) The availability of dental services to the handicapped

should be further improved by the payment of fees authorised on a discretionary basis by the dental estimates boards.

(43) The Government should introduce legislation to compel water authorities to fluoridate water supplies at the request of health authorities.

(44) The health departments should pursue an active policy in restricting advertising which may lead to undesirable dietary habits, particularly in children.

(45) The dental profession should consider ways of overcoming the problems of long-term clinical research in dentistry.

(46) A small committee representing Government and the other interested parties should be set up to review the development of dental health policy.

(47) The health departments should promote more research both on the acceptability of day admissions to patients and on the benefits to the NHS.

(48) All hospitals should provide facilities for patients and relatives to be seen in private.

(49) All hospitals should provide explanatory booklets for patients before they come into hospital.

(50) Hospitals should ensure that the availability of amenity beds is routinely made known to patients when they are given a date for admission.

(51) Health authorities should review forthwith wakening times for patients in the hospitals for which they are responsible.

(52) The health departments should now state categorically that they no longer expect health authorities to close mental illness hospitals unless they are very isolated, in very bad repair, or are obviously redundant due to major shifts of population.

(53) The Government should find extra funds to permit much more rapid replacement of hospital buildings than has so far been possible and they should stick to their plans.

(54) Community health councils should have right of access to family practitioner committee meetings and their equivalent in Scotland and Northern Ireland. If FPCs are abolished as we propose CHCs should have access to the committees which take over their functions.

(55) CHCs should be given more resources to enable them to inform the public fully about local services.

(56) More resources should be made available where necessary to allow CHCs to act as the "patient's friend" in complaints procedures.

(57) Health departments and health authorities should continue to give financial support and to encourage voluntary effort in the NHS.

(58) Financial support should be given to encourage the setting up of patient committees in general practice.

NHS and its workers

(59) The health departments and staff organisations and unions should give urgent attention to industrial relations training for both staff representatives and management.

(60) The TUC should take the necessary steps in initiating discussions on a procedure for dealing with national disputes in the NHS which must involve not only those bodies affiliated to the TUC but bodies representing the interests of other NHS workers as well.

(61) The health departments should intervene on those occasions when the health professions cannot reach agreement on staff roles.

(62) The joint higher training committees for postgraduate medical education should approve only those units and departments where an accepted method of evaluating care has been instituted.

(63) A planned programme for the introduction of audit or peer review of standards of care and treatment should be set up for the health professions by their professional bodies and progress monitored by the health departments.

(64) The health departments should undertake, approximately every two years, a review of the medical manpower position, following open and public discussion and supported by better data than has so far been available.

(65) Experiments with different mixes of staff in different contexts and the development of interprofessional training should be encouraged.

(66) The NHS should assume the same responsibility as any other employer for the health and safety of its staff and set up an occupational health service.

(67) The profession and the health departments should encourage and pursue experiments in the development of the nursing role.

(68) Research is required into the effect of the use of unqualified nursing staff on patient care and into the best composition of the ward team in different settings.

(69) The health departments should undertake such central manpower planning as is necessary, that is develop a national recruitment policy, assist the setting of standards and objectives, propagate good practice, and ensure an adequate data base, which will be of considerable importance to the new statutory educational bodies.

(70) The clinical role of the nursing officer should be developed along the lines envisaged by the Salmon Committee.

(71) The development of specialist knowledge and nursing skills both in the community and hospital should be encouraged.

(72) Health authorities should establish budgets and develop programmes of post-basic nursing education for their staff.

(73) Developments of joint appointments between schools of nursing and the service should be vigorously pursued.

(74) The health departments should show more determination in enforcing their priorities in the medical staff shortage specialties, if necessary by blocking expansion of other specialties, and should be more critically involved in the development of new specialties.

(75) The development of special interests in shortage specialties among doctors working in related fields should be encouraged and appropriate training programmes provided.

(76) The UK Government should take the necessary steps to make clear to doctors who want to come to the UK what their prospects here are.

(77) A few postgraduate centres to provide medical education and training specifically geared to the needs of overseas countries should be started on an experimental basis.

(78) Community physicians should be given adequate supporting staff.

(79) A salary option should be introduced and open to any GP who prefers it.

(80) There should be an independent review of the machinery set up by the Professions Supplementary to Medicine Act 1960. It should include manpower and training needs of the professions.

(81) The health departments should continue their efforts to generate more research into the work of speech therapists, occupational therapists, physiotherapists, and remedial gymnasts.

(82) Staff in senior posts in the scientific and technical services should normally be science graduates.

(83) Pilot experiments should be carried out in providing a regional scientific service for one or more laboratory specialties.

(84) The head of a laboratory should be the most able scientist available.

(85) In one or two instances the accident and emergency ambulance service should be organised experimentally on a regional basis with "community transport services" being provided by the lower tier NHS authorities; and the results closely monitored.

(86) Health authorities should ensure that adequate induction training (including access to language courses where appropriate) is available for ancillary staff.

(87) The works staffing structure should be kept under review by the health departments, as should the numbers and training of craftsmen.

NHS and other institutions

(88) Before any collaboration begins, its purpose, form, and resource implications should be identified with the different agencies and professions involved.

(89) In Northern Ireland the present integration of the health and personal social services should be encouraged and further developed.

(90) There should be more emphasis in the education and continuing training of health and social work professionals on the importance of interprofessional collaboration.

(91) There should be no radical change in the responsibilities for either the health or the personal social services.

(92) A formal structure at national level to co-ordinate the policies of the health departments, the University Grants Committee, and the universities should be considered by the parties concerned.

(93) An independent inquiry should be set up to consider the special health service problems of London, including the administration of the postgraduate teaching hospitals, whether London needs four RHAs, whether some special adjustment to the RAWP formula is required to take account of the high concentration of teaching hospitals in London, and what additional measures can be devised to deal with difficulties of providing primary care services and joint planning in London.

(94) NHS staff who are required to teach students should have this requirement written into their contracts.

(95) The health departments should as a matter of national policy fund chairs or senior lectureships, or promote joint NHS/university appointments, as in Northern Ireland, in the priority specialties.

(96) Universities should encourage and monitor experiments in different approaches to student selection which take account of factors other than traditional academic criteria.

(97) An Institute of Health Services Research should be established for England and Wales to encourage systematic research into health care issues and its activities and output should be carefully evaluated. The health departments in Scotland and Northern Ireland should consider their position as separate institutions may not be appropriate there.

(98) Health authorities in Great Britain should have the broad objective of providing for about 75% of all abortions on resident women to be performed in the NHS over the next few years.

(99) The capital element of pay-bed charges should cover both the interest and depreciation costs of the capital investment in pay-beds.

(100) The Health Services Board should be given power to control, and a responsibility to consider, the aggregates of beds in private hospitals and nursing homes when any new private development is considered in a locality.

Management and finance

(101) A select committee on the NHS should be set up.

(102) Formal responsibility, including accountability to Parliament, for the delivery of services should be transferred to regional health authorities.

(103) The health departments should give further guidance about the role of members of consensus management teams.

104) The health departments should urgently consider with the professions concerned the best way of simplifying the present professional advisory committee structure.

(105) The role of the hospital administrator at unit or sector level should be expanded.

(106) There should be a review of the number of functional managers above unit level.

(107) Regional health authorities in England should continue to be responsible principally for planning and for the major functions they carry out at present.

(108) Below region in England, and elsewhere in the UK below health department, except in a minority of cases, one management level only should carry operational responsibility for services and for effective collaboration with local government.

(109) Each regional health authority in England and the health departments in Scotland, Wales, and Northern Ireland should institute a review of the structure for which it is responsible. The Department of Health and Social Security should monitor this review in England.

(110) Family practitioner committees in England and Wales should be abolished and their functions assumed by health authorities as a step towards integration.

(111) The process of introducing the changes recommended should be completed within two years of the end of the period of consultation.

(112) It is for Government to decide how the NHS should be funded, but there is a firm case for the gradual but complete extinction of charges.

(113) The health departments should prosecute the research necessary for improvement of the resource allocation formulae.

(114) There should be an explicit formula for the distribution of funds to the health service in the four parts of the United Kingdom.

(115) The main proposals of the Collier report on equipment and supplies should be implemented as quickly as possible.

(116) Health departments should encourage experiments with budgeting.

(117) A study of the desirability and feasibility of common budgets for family practitioner services and hospital and community services expenditure should be undertaken.

The future

We believe that the recommendations we have made will, if accepted, make the NHS more suited to caring for the health of the nation now and in the future. But there are numerous influences on the need for health services not all of which are predictable. This is a highly speculative area, but we felt that we should sketch out some of the more obvious possibilities.

The demographic change which will be the greatest single influence on the shape of the NHS for the rest of this century is the growing number of old people and particularly those over 75. This will increase the need for long-term care. In addition,

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demand for services for the mentally ill and the mentally handicapped are likely to grow.

Changes in social attitude and life-styles could be of great significance, but their direction and extent are unpredictable. We do not know, for example, what percentage of women with families will wish to go out to work and over what period or periods in their lives. What they do will affect the care of old people, sick people, and of children, and may influence significantly the emotional stability of children. Life-styles of young people in this country have changed dramatically since the NHS was established and further change is certain. Habits of eating, taking alcohol, and sexual behaviour could alter with profound effects on health. Groups of the population, now uncaring for their health, might become more self-conscious and take a pride in it, reducing the burden on health services.

Advances in the sciences basic to medicine will increase knowledge of the causation of disease and thus assist towards its control. Advances in molecular and cell biology, for example, will lead to a better understanding of genetic susceptibility and of some inherited diseases. Immunology is at present a thriving science within medicine. New drugs have in the past decade greatly assisted the treatment of peptic ulcers, asthma, hypertension, Parkinson's disease, and some blood cancers; and there is every reason to think that progress in pharmacology will continue. Psychology is contributing significantly to the treatment of disturbed behaviour in the neurotically ill and the mentally handicapped. Sociological insights are illuminating the interaction between the providers of services and the patients who seek their help.

The impressive contribution which acute medicine has made in relieving illness and suffering seems likely to continue. Diagnosis is continually being improved and refined by technological developments. Techniques such as tomography, ultrasound, and radioisotope scanning have been major advances. Analytical tools of great importance such as mass spectrometry, radioimmunology, and radioenzymatic techniques have been added to the battery of 100 or more tests and investigations which a clinical laboratory in a district general hospital now provides. Advanced technology has contributed to the development of incubators for premature babies, renal transplantation, cardiac pacemakers, and hip replacement. It is likely that bioengineering will increasingly assist orthopaedics. At the same time the emphasis on acute and high technology medicine is being challenged and more thought is being given to the care of the chronically sick and elderly. These developments are likely to continue.

Computers will more and more be used in most areas of medical research and practice, in the laboratories, in patient information services, in hospital wards in monitoring patients as well as in recording data about them and the drugs which they receive. Diagnosis in some fields is already being considerably assisted by computers. The microelectronics revolution is certain to have a major impact in medicine, to a degree which it is likely very few of those working in the NHS at present envisage. Improved data collection would assist better planning services.

Technological and service developments in the NHS have implications for its cost. The NHS has already to spend about 1% more each year merely to provide its existing standard of service on account of the increasing numbers of elderly. While some scientific advances reduce costs, most tend to increase them, so the future state of the national economy will have an important influence on the NHS and its capacity to provide new or better services.

One aspect of the NHS which is unlikely to change is the importance of its staff. By its nature the NHS is labour-intensive and this places a special responsibility on it to enable its workers to contribute in an effective way.

Predictions can be made by extrapolation from the state and the trend of things now. It is possible, however, that the greatest changes will come unexpectedly. Certainly changes in society which could potentially have the widest effects are also the least predictable. The NHS should therefore be geared for the maximum flexibility in response.

In our review of the NHS as it exists we found much about which we can all be proud. Our examination of foreign health systems for the most part reinforced that view. If in considering some aspects in detail we have made specific criticisms, we have done this in the hope that in the future the NHS can provide a better service, not because we think it is in danger of collapse. The developments which we have suggested the future might bring will produce considerable change for the service and those who work in it. We are confident that they will meet the challenge.

Ancillary staff pensions dispute settled

The Chairman of the General Medical Services Committee has reported that the dispute with the DHSS over ancillary staff pensions has been resolved. Dr R A Keable-Elliott told the committee at its monthly meeting on 19 July that as a result of discussions with the Minister of Health it has now been agreed that FPCs will be authorised to reimburse contributions in respect of staff for whom private pension arrangements have been made up to and including 6 March 1978, irrespective of subsequent variations in contributions and irrespective of whether those schemes have been accepted or rejected since that time by FPCs or on appeal by the Secretary of State. It has also been agreed that staff employed since that date as replacements for other staff previously included in superannuation schemes may qualify for reimbursement, but individual cases would be considered by DHSS in consultation with the GMS Committee.

Only reasonable contributions, defined as up to 15%, will be accepted for reimbursement. Where, however, the contribution is above 15% of the employee's salary but the average contribution for all the staff is 15% or less, the whole of the contribution will be reimbursible. Where a contribution is being made in excess of 15% and the average is above 15% the Department will authorise reimbursement of up to 15%, with the doctor meeting the difference, provided the circumstances are considered to justify a higher contribution—for example, where an employee has worked for a doctor for many years and is coming up to retirement. Where applications for reimbursement were made before 1 October 1978 but were rejected the schemes may be reconsidered *provided they have not been cancelled and are resubmitted by 1 October 1979.*

It has also been accepted that where schemes are approved for reimbursement, contributions may increase in line with percentage increases in salary levels. The Minister, however, has stipulated that as from Wednesday, 18 July no further members of staff, whether replacements or not, would be accepted under the scheme for reimbursement of pension contributions unless the pension scheme specifically either provides for pension contributions in respect of "post" holders, as opposed to individual named employees, or if the scheme entered into by 6 March 1978 was expressed to apply to, or provide cover for, ancillary staff employed by the practice from time to time.

The committee has accepted this negotiated "package." As there is no longer any limit on the level of salary which may be paid to ancillary staff under the ancillary staff scheme, there would be no reason why new members of GPs' staff could not be paid at a higher rate from which they could make their own pension arrangements if they so wished. Individual practitioners affected should await the formal amendments to the Statement of Fees and Allowances before approaching their FPCs. Advance copies of the SFA amendments should reach FPCs within two or three weeks. The revised rules do not apply in Scotland.

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